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I. Background

The uninsured population in Illinois exceeds 1.2 million with 60% of those individuals working in small business firms (25 or fewer employees) that do not offer health coverage. The Illinois Department of Insurance ("Department") is seeking a qualified entity to develop a pilot program designed to offer employer-based coverage to small businesses in Illinois.

HMA, in partnership with the Southern Illinois Healthcare Foundation (SIHF), proposes to design a small employer health insurance pilot in St. Clair County – the Southwestern Illinois county anchored by East St. Louis. The pilot would be based on a three-share model (i.e., costs are split between employer, employee and a public subsidy) and would be developed using a community input process that HMA has employed successfully in more than a dozen similar projects in four states.

A. Health Management Associates

Health Management Associates (HMA) is one of the nation's leading firms in the development of local, community-based approaches to the expansion of access to health care and the reduction of the number of uninsured individuals. Attachment A, *HMA Experience*, describes various projects where HMA has been engaged to help communities design and implement solutions to the problems surrounding the uninsured.

In addition to this valuable experience, HMA staff are uniquely qualified for this work in that many of our staff have extensive experience as senior state health or Medicaid officials. HMA staff have significant experience with the development of creative financing initiatives through which funding has been made available to support new programs for the uninsured. Biographical information on project staff appears in Section V, "Project Team," and resumes for these individuals are included in Attachment B.

The material that follows describes how HMA will accomplish the following principal objectives:

- *Cost-effective coverage*. The development of a small employer strategy, which will make available a carefully designed health plan to: (1) provide coverage for small employers; (2) provide appropriate incentives to improve health and control utilization costs; and (3) not compete with commercial plans.
- *Community input and participation*. The creation of a community-based primary care delivery and funding mechanism for the employed/uninsured, using a three-share model of employer, employee, and community participation.
- *Replicability.* The development of a strategy that enhances the opportunity for replicability in other communities by developing and documenting the fundamental dimensions of the program (e.g., eligibility, plan design, funding models) and the specific decisions made during the development process.

B. Southern Illinois Healthcare Foundation

HMA is proposing to implement a pilot program in St. Clair County in partnership with the Southern Illinois Healthcare Foundation, a Community Health Center that provides comprehensive primary health services to residents throughout Southwestern Illinois. SIHF has 41 providers and provided more than 86,000 patient visits in 2002. Access to the full continuum of care is provided through SIHF's affiliation with Touchette Regional Hospital and its partnerships with specialty care providers throughout the region.

SIHF is well respected in the community and has established itself as a leader nationally in providing access to care and reducing health disparities at the local and regional levels. SIHF has distinguished itself with four national awards since 1995 (National Committee For Quality Healthcare, Models That Work, Monroe E. Trout Premier Care Award, and the Foster G. McGaw award). We believe these qualities make SIHF an ideal partner for this pilot effort.

II. Methodology

A. HMA's Approach

HMA has implemented or is in the process of implementing more than a dozen community-based uninsured programs in four states. A number of these programs have operated successfully for several years (see Attachment A, *HMA Experience*). We believe our success in this area is due to our process-based approach that helps communities develop programs that meet their unique needs, rather than applying a "one-size-fits all" model. HMA's approach recognizes that each community has a unique population, legal and regulatory structure, provider market, and insurance market. We recognize that communities have varying attitudes toward, for example, co-payments versus first-dollar coverage, or open versus closed provider networks. We also recognize that local medical and business communities have varying attitudes toward the uninsured and the role of health insurance as an economic development tool.

Understanding these variances, HMA's approach is to apply a detailed and tested process to harness the input of the community and, using HMA's technical expertise of health insurance and financing models, convert this input into a viable program for the community. The likelihood of success is optimized by weaving community input into effective insurance models that can be taken to market.

B. The Three-Share Model

Within this overall approach, HMA proposes to design a program based on the three-share model, with costs split by the employer, employee and a public subsidy. This model has several advantages that are important to the sustainability of the program:

- By splitting the financial responsibility for the program, it ensures that each party – employers, employees and the community – have a vested interest in making the program successful; and perhaps more important,
- The public subsidy stabilizes the program by making it inexpensive enough to retain lower-cost employees. Without the subsidy, these employees may be able to find less expensive insurance products elsewhere, which would de-stabilize the risk pool and eventually bankrupt the program.

C. Replicability

Throughout the process, each program dimension, and the decision points connected to each program dimension, is carefully documented to build a framework for replicating the process in other communities. This documentation will be compiled to form a "Policy User's Guide" -- an important product for the Department of Insurance. The Policy User's Guide will serve as a guide to the issues to be confronted in developing a plan of coverage, with the Pilot as a case study for why it was done a particular way in a given community.

Examples of these program dimensions and examples of options are outlined in the following table.

Key Dimension	**Examples of Options**
Program Model	• Affordability vs. Comprehensive Coverage • Underwriting by firm vs. community subsidy
Payment Methodology	• Fee-for-Service vs. Capitation
Benefit Plan Design	• Scope of Coverage • Supplemental riders
Cost Sharing Levels	• Premium Cost vs. Cost Sharing through Deductibles, Coinsurance, or Copayments
Employer, Employee, and Dependent Qualifiers	• Maximum or Median Wage Rate • Location – Residence/Work • Business size • Work history • Pre-existing conditions • Amount of dependent coverage/subsidy
General Administrative Options	• Annual Open Enrollment • Proof of Employment • Cut off dates for new hires and qualifying events • Documentation requirements to verify address and qualifying events

The method for developing this Policy User's Guide will be to document and explain the options considered throughout the process. For each of the dimensions to be addressed, HMA will prepare a clear profile of the different options or approaches that might be considered within each. Additional or hybrid approaches may also be added.

For each dimension, HMA will produce the option profile and a summary of the reasoning why a particular option was selected. This output will provide the Department with a demonstrable product from the pilot that will facilitate replicability of the process, and help stakeholders understand the variation that was initiated.

D. Product Design

HMA understands that the real objective of the Pilot Demonstration is not to develop the single plan of benefits that might be replicated in selected sections of the state. The real objective is to make a market that succeeds locally and which will flourish statewide with proper enabling policies. HMA is proposing to use a community process to design a subsidized small-employer insurance pilot. Throughout the program design process, HMA will work with the community to address each of the specific issues and design elements raised by the Department in the RFP. These include employer eligibility (e.g., employer size, non-provision of health insurance), employer enrollment periods (e.g., specified open enrollment periods, lock-ins), employee eligibility (e.g., part time/full time, spouse, family), insurance methodology (e.g., community rating, composite rate, banding), plan administration (e.g., TPA, carrier, in-house), benefit design (e.g., primary/preventive emphasis, catastrophic emphasis), formulary issues (e.g., emphasis on generics, preferred drug lists), payment issues (e.g., copays, deductibles, MSAs) and other issues. Please see Section IV, "Workplan" for a detailed description of the process for analyzing and making decisions on each of these issues.

HMA is proposing to develop a pilot based on the three-share concept with which we have substantial experience. In this pilot, the premium will be apportioned between the employer, the employee, and a community subsidy. Typically, these shares are a third each, but the proportions can be influenced by the structure of the small group employment base; how much would the employer(s) be willing to pay, as well as the employee's salary.

The health care coverage plan that can be implemented on a pilot basis needs to be voluntary. The pilot region or community cannot legislatively compel employers to participate (an option potentially available to the State). The plan developed has to be affordable and attractive to smaller employers. Consequently, the offered plan has to meet the needs of the employer and the employee, and it has to have a perceived value as an incentive to participate.

Below we discuss how HMA's approach and model will: 1) control costs and maintain stability in the program; 2) engage the community in an interactive program design process; and 3) ensure that employers are committed to the success of the program.

Stability and Cost Control

Clearly, affordability and premium stability are two major factors inhibiting smaller employers from electing current small-group commercial coverage. Employers who may be tempted to try commercial coverage may face substantial underwriting and premium spikes, leading them to shop other carriers, lower their coverage, or drop coverage

altogether. Insurers consider the small groups too volatile, and assume the disproportionate presence of adverse selection.

A purchasing pool may be considered, but the approach is inherently unstable on a local basis. Too frequently, as rates rise the healthier individuals and firms opt out. What is highly desirable is for an insurer to view the plan with a significant number of employers as a larger group, and rate it on that basis.

The plan to be developed anticipates that firms will be attracted because a plan of a demonstrable value will be offered on a basis close to a common community rate. The proposed one-third share of the developed plan that would be subsidized is sufficient to preclude employers from withdrawing and pursuing alternative coverage that is less expensive, because no other coverage will be less expensive (once the employer gives up the subsidy).

Consequently, insurers are becoming increasingly responsive to the perceived stability of this pool of smaller employers. Insurers understand that the subsidized portion stabilizes the block of business, because a given firm likely will not withdraw based on cost until it wants to move up to a higher level of commercial insurance.

The notion of "a higher level of commercial insurance" is also important. In order to obtain a total premium that is affordable to small employers not currently offering coverage, the plan benefits have to be less costly than commercial packages for small groups. The benefits will be thinner rather than richer. This enhances affordability, and equally significantly guards against crowd-out (firms currently offering coverage dropping their plans to elect the new program). Other policy actions can effectively guard against crowd-out; one example would be an eligibility requiring the applicant firm to have been without health coverage for a period of a year or more.

The Plan of Benefits: Bringing Community Design to a Statewide Insurance Market
The actual plan of benefits to be offered needs to: 1) be developed with the community and; 2) approximate products that can be found in the marketplace. For this pilot, the plan must also be qualified by the Department of Insurance as meeting all regulatory requirements. A particular community can adopt a plan of benefits that is traditional but limited, a managed care plan, a catastrophic plan, or a plan that is "consumer-directed" along an MSA type structure. It could be oriented to primary care or not. The resources available (for subsidization) as well as economic price points for the employer and the employee will influence the design.

For example, the following table displays three different sets of benefits adopted by three Michigan counties that have developed three-share plans. The programs differ significantly, but work well for each county:

Employer Subsidy Program
Comparison of Key Benefits

Covered Service	Wayne County's HealthChoice	Muskegon County's Access Health	Kent Health Plan
Primary care provider office visits	$5 per visit	$5 copayment per visit $10 Pre-natal and post natal care ($110 maximum copayment)	$15 per visit
Specialty care office visits and services	$5 per visit	$20 per visit	$15 per visit
Inpatient hospital	Limited to 20 days per year $0 copayment, Unlimited days covered only through purchase of supplemental rider	$100 copayment per hospitalization	$100 per admission; limited to 20 days per year
Emergency Room services	$25 copayment if admitted, $75 copayment if not admitted $75 copayment out-of-area	$50 copayment waived if admitted. Covered only in Muskegon County	$50 per visit
Outpatient prescription drug services	$5 generic or DAW, $10 brand name, 50% copayment on psychotherapeutic drugs	$5 Generic, 50% name brand, supplies needed to administer meds, 20%	$5 generic; 50% brand; use KHPC Plan B formulary
Outpatient hospital services	$0 copayment	$50 copayment per hospitalization	$20 per visit
Ambulance services	$0 copayment	20% copayment	10% copayment
Durable medical equipment	Covered only through purchase of supplemental rider	20% copayment	20% copayment
Outpatient physical therapy	Covered only through purchase of supplemental rider, $10 copayment	$5 copayment	$0 copayment
Vision exams and glasses	Covered only through purchase of supplemental rider	Not covered (unless vision exam is due to injury or disease)	Not covered
Inpatient drug and detox	Covered only through purchase of supplemental rider, $20 per episode (limit 2 episodes per enrollment year; 72 hours per episode)	$20 copayment/visit $100 copayment per hospitalization Up to 10 days and 20 outpatient visits per year	$100 per admission; limited to 10 days per year
Dental Services	Covered only through purchase of supplemental rider	Not covered	Not covered

Rockford (Winnebago County, Illinois) provides an example of different models that were acceptable to the community and were offered in the RFP as "types" of plans with actuarial values that fit the projected budgets. In this case, the two models were very different. One was a more conventional plan of coverage, while the other emulated a consumer-directed approach with a high deductible:

ROCKFORD HEALTH COUNCIL: WINNEBAGO COUNTY ONE-THIRD SHARE UNINSURED PLANS (RFP Proposed)

Medical and Rx Services	PLAN A	PLAN B		
		Basic Benefits	**Self-pay Corridor**	**Insured Benefits**
Prima care provider office visits	$10 copay per visit	$10 copay per visit	100% of Medical and Rx Paid by Plan Participant at Negotiated Rates	$10 copay per visit
Urgent Care	$25 copay per visit	$10 copay per visit		$10 copay per visit
Immunizations	No copay	No copay		No copay
Specialty care office visits and services	$10 copay per visit	$10 copay per visit		$10 copay a per visit
Inpatient hospital	$50 per day copay; Limited to 10 days/year	Not covered		100% to max after deductible
Emergency Room services	$50 copay, waived if admitted	$50 copay, waived if admitted		$50 copay, waived if admitted
Annual Maximum Benefit - Medical and Rx	None	$600		$25,000
Deductible Per Individual	None	None		$2,000 including Rx
Outpatient prescription drug services				
Generic	$10 copay per script	100%		$10 copay per script
Brand on Preferred Drug List (PDL)	$15 copay per script	100%		$15 copay per script
Brand not on PDL	$50 copay per script	100%		$50 copay per script
Outpatient hospital services				
Surgery	20% copay to S50	$10 copay per visit		$10 copay per visit
Laboratory Tests	100%n	$10 copay per visit		$10 copay per visit
Diagnostic X-rays	100%	$10 copay per visit		$10 copay per visit
Ambulance services	10% copay	Not covered		100% to max after deductible
Durable medical equipment	$100 copay per item	Not covered		100% to max after deductible
Outpatient physical therapy	$15 copay per visit	$10 copay per visit		$10 copay per visit
Vision exams and lasses	Not covered	Not covered		Not covered
Dental Services	Not covered	Not covered		Not covered
Home Health	Not covered	Not covered		Not covered

Plan takes in $100 monthly ($50/$50 EE/ER). The EE contribution pays for the basic benefits that have a $600 annual maximum. The ER and Community contributions pay for administration and buy the insured coverage.

In fact, the plan selected by the Rockford Health Council was ultimately different than both of the developed sample plans, but it met the Committee's criteria and was an appropriate insured plan with an actuarial cost and value within the predetermined targets.

The Rockford RFP was the first test of the insurance markets in Illinois for this type of coverage. What distinguishes Rockford from the predecessor plans in Michigan is the initial requirement for an insured plan, which Michigan did not have. Consequently, with a considerable investment of time in pre-conditioning the market, six commercial entities attended the bidders' conference, and two proposals were received. In the subsequent marketing of the Macoupin County three-share plan, three carriers submitted their own plans of benefits that were deemed to come closest to the County's requirements. The Macoupin submissions are substantially different from the Rockford submissions, demonstrating the impact of the community design process and the growing responsiveness of carriers. We anticipate an even stronger showing for this pilot.

Indeed, for the State to sponsor a successful pilot, the selected contractor will have to be able to balance community-based design, and lead that process with the credibility that accompanies experience with insurance markets. HMA has this experience and credibility. Once again, the objective is to create insurance markets that will be attractive to small employers not currently offering affordable health coverage. HMA's plan is to bring to market a plan that is understood and accepted by the community.

Employer Commitment and Incentives

Employers in the St. Clair Pilot are likely, because of the insurance markets, to have one-year renewable contracts. There could be an explicit but perhaps non-binding commitment to two years. Because of the subsidy under the three-share model, employers are not anticipated to withdraw for any reason other than inability to meet the premium. Both the subsidy and the plan design, which will be thinner than commercial plans, would preclude employer withdrawal for less costly insurance.

An employer withdrawing to purchase higher small-group coverage in the commercial market would be good. Ideally, a number of employers would move up to commercial plans with deeper coverage over time. A prime objective of the Pilot should be to offer stable coverage over time, drawing non-providing employers into coverage, but not to keep firms from improving the coverage they provide.

The problem of how to keep cost and cost increases to a minimum to assure continued participation will be explored in the Pilot. It will be first anticipated in the design and by the response to the market. Properly constructed, we do not anticipate that the working uninsured are necessarily an adverse group. They are younger, and more typically need coverage such as maternity or trauma, and may well have a lower than expected utilization. Plan design and firm eligibility will have significant bearing on the costs. This is obviously a key issue and needs to be tested.

E. Other Approaches

As a result of our work on the State of Delaware's HRSA State Planning Grant and other projects throughout the country, HMA is very familiar with various models for covering the uninsured. Below are several approaches that HMA reviewed as part of our work (see Attachment A, *HMA Experience*). In developing this proposal for the Illinois Department of Insurance, HMA considered a number of these and other approaches to addressing the issue of the employed uninsured. The community-driven process model and the third-share approach were selected because we believe they provide the state with the greatest likelihood of developing a successful, replicable pilot.

Approach	Reasons Discarded
Tax credits for employers	• Many employers not now offering coverage are likely to be small, marginal firms, hiring low-wage employees. They may not generate significant profits and thus may not incur much tax liability; so unless the tax credit was "refundable" and quite large, they might not get much benefit from a tax credit and thus would not participate. • Employers would still have to pay a significant portion of the premium from their own funds, which may be more than marginal firms can afford. low-wage employees might prefer to have any increased compensation in the form of higher money wages. Might have little impact on covering the uninsured. • Credits that are available only at the time of tax filing would not make insurance coverage affordable for employers who have insufficient monthly income to pay the insurance premiums during the year. • Because tax credits must be large to be effective, approach would have a significant budgetary impact in form of forgone tax revenues. • Some employers already providing coverage would take advantage of the tax subsidy and cut back on their contribution.
Subsidized "buy-in" to state employees plan	• Potential for substantial "crowd out." • Because the providers serving these people would be doing so on the same terms as for state employees, the budgetary cost would be higher than if the people were enrolled in a program in which providers accept reduced rates. • State employees might strongly object to the inclusion of this group, for fear that their inclusion would result in unfavorable changes in the state's benefits, or that the risk profile would worsen and costs per enrollee would rise, etc. • Assuming many of the eligible people would have children in SCHIP, the adults and children would be in separate health plans.
Benefit limited to emergency and hospital coverage programs	• Approach fosters continuation of a fragmented safety-net approach to health care. • Continues reliance on hospitals to fund, through cost shifting and disproportionate share payments, the cost of care for the uninsured.

Premium assistance through SCHIP for available employer coverage	• Potential for greater crowd-out: some low-income families now paying for employer-based coverage might drop it, knowing that they are eligible for the same coverage on a subsidized basis: employers could reduce their contribution and state subsidies would fill-in for the cost employees would otherwise bear. • Implementing such a program is complicated, partly because of all the federal requirements: • Approach does nothing for SCHIP parents whose employers do not offer coverage, and it does nothing for uninsured adults who do not have children eligible for SCHIP.
Small-group and/or individual insurance reforms	• Would not help people who cannot afford average-priced insurance. • The likely effect of this approach in the individual market, and if individuals (as "groups of one") are included in the small employer market, is to raise the average price somewhat because of the inclusion of more high-risk people, which would likely cause some people to drop coverage and/or require substantial cross-subsidies of individual market coverage. • This approach is likely to be strongly opposed by some insurers. • Some insurers with a weak commitment to the state might decide to no longer sell individual or small-group coverage in the state. • A guaranteed-issue requirement with such rating reforms in the individual market is likely to result in a significant influx of high-risk individuals, because individuals tend to buy coverage when they know they will need medical services. This would likely cause a significant increase in rates, which would cause some people to drop coverage.
Small employer subsidized purchasing cooperatives	• The subsidy must be large enough to attract participation of significant numbers of uninsured small employers and employees. Otherwise, the pool cannot significantly reduce the number of uninsured, and will not have sufficient enrollment to attract the participation of the health plans on terms needed to make the pool a success. • Some important interests may oppose the creation of such a purchasing pool, favoring subsidies that are used to buy into existing private coverage sources.

"Bare-bones" insurance – primary care	• From an actuarial standpoint, such coverage is more pre-payment than insurance: the cost of the policy is not likely to be much lower than the sum of what the typical person would pay out of pocket during a year if he or she paid for services as they are used. There is little spreading of risk of the cost of unpredictable losses, which is the purpose of insurance. • The coverage provides no protection for those people who need really expensive care. Those who needed such care would be left with a major financial burden, and the costs would often have to be absorbed by providers. • Allowing sale of such coverage sets what many would see as a bad precedent by allowing sale of coverage that provides inadequate protection against the kinds of expensive events that are the real purpose of the insurance. • Insurers who sell such coverage may become victims of adverse selection: people who find the coverage attractive are likely to be those who know they will need many of these services. Healthy, young adults will often see little benefit in buying such coverage.

III. Pilot Site and Covered Population

A. Appropriateness of the Pilot Site

HMA chose to work with the Southern Illinois Healthcare Foundation in St. Clair County for a number of reasons:

- *Strategic geographic location.* HMA is preparing to launch a three-share program this spring in Winnebago County (Northern Illinois) and is currently reviewing bids for a similar program in Macoupin County (Central Illinois.) The addition of a pilot program in Southern Illinois presents a unique "laboratory" in which to observe and evaluate this approach in three very different communities. Successful implementation in these varied communities greatly enhances the likelihood that this approach could be "taken to scale" statewide.

- *Ideal target population.* With its relatively high rates of unemployment and uninsurance St. Clair County presents a significant challenge for policymakers. Implementation of a pilot in St. Clair County will be a new test for the community process approach and three-share model, one, which we believe, will be met successfully. With its high rates of unemployment, St. Clair also presents a unique opportunity to evaluate the potential of this model as a community economic development tool.

- *Opportunities to help stabilize the medical community.* Unlike the two other communities in Illinois where HMA is implementing three-share plans, St. Clair County is a large medically underserved area, presenting a significant additional challenge. The long-term success of the pilot will largely hinge on securing buy-in and participation from the local medical community.

- *Strong partnership.* HMA's experience in designing and implementing programs for the uninsured has taught us that strong local leadership is critical to the success of the program. We have chosen to partner with the Southern Illinois Healthcare Foundation, one the regions largest healthcare providers, because we believe they will be able to help us leverage the resources of the community to design an effective program.

B. The Covered Population

HMA's proposed pilot will be implemented in St. Clair County, in the region anchored by East St. Louis. HMA is estimating that of the approximately quarter of a million people in St. Clair County (256,599 in the 2000 Census), approximately 33,000 (13%) are uninsured. This is based on the higher estimate of the State's overall range of uninsured produced under the State Planning Grant. Understanding that unemployment in East St. Louis is higher than the state, and assuming 50% of the uninsured are employed (as opposed to 60% to 70% elsewhere), then approximately 16,500 people are likely to be working uninsured.

Additionally, on a preliminary basis, we estimate that between 25,000 and 50,000 people are working in about 5,000 non-farm businesses that average 5 to 10 employees. Using small-employer data from the State Planning Grant, if 40% of those do not have access to employer-sponsored insurance, then between 10,000 and 20,000 persons would be in target firms, prior to establishing wage-based or other eligibility criteria for firms, such as size and median wage. This range brackets the estimated 16,500 working uninsured developed above under the first method.

Consequently, the pilot might reasonably target enrollment of 6,000 people by the end of three years (a little more than 1/3 of the initially estimated working uninsured).

IV. Work Plan

The following table details HMA's proposed process for designing and implementing a subsidized small employer health insurance program in St. Clair County. Estimated completion dates for each phase are also noted.

Phase 1: Analysis of Working Uninsured Market in St. Clair County (Completion Date: February 28, 2003)
Task 1.1: Collect and analyze available data on the number and demography of the uninsured in the market area. Special attention will be paid to the working uninsured within the minority community in the County.
Task 1.2: Develop report based on analysis of available data and present report. • HMA staff will analyze responses, develop a report and present tabulations of results to Southern Illinois Healthcare Foundation and the DOI that are statistically meaningful. This includes observations regarding preferences on plan design, price barriers to participation.
Task 1.3: Evaluate opportunity to partner with the Southern Illinois Healthcare Foundation to implement a program that would significantly reduce the number or working uninsured within the County.
Phase 2 – Project Feasibility (Completion Date: March 28, 2003)
Task 2.1: Assess preliminary ownership of the project, including legal, political, operation, and other aspects. • HMA staff will work with Southern Illinois Healthcare Foundation to identify key stakeholders in the community with leadership interest in the project. We will assist in developing the organizational structure, including designating responsibility for program design, fiduciary responsibility, and operational control.

Task 2.2: Determine key constituencies and assess potential barriers to success.
• HMA staff, working with Southern Illinois Healthcare Foundation staff, will assist in identifying key constituencies.
• HMA staff will hold several meetings with key constituencies to gain input, including potential opportunities for and obstacles to, the project's success. We will hold meetings with representatives from each of the following interest groups:
  • Local business leaders
  • Economic development groups

- Physicians and other providers
- Health systems and community health centers
- Commercial health insurers
- Political leaders
- Church leaders
- Chamber of Commerce
- Appropriate community agencies
- All local public health agencies

Task 2.3: Solicit feedback and obtain buy-in to develop the overall project plan and health benefits design

- The constituency meetings, as described in Task 2.2, will also be a venue for community and HMA staff to educate stakeholders about the program and obtain their buy-in.

Task 2.4: Determine preliminary actuarial and legal needs and costs.

- HMA staff will work to identify actuarial needs including assessment of various health benefit packages, eligibility criteria, and reimbursement policies, including co-payments.
- Preliminary recommendations by the community based on information from existing plans and data on the following issues will be explored and decided:
    - Employer eligibility (e.g. employer size, non-provision of health insurance);
    - Employer enrollment periods (e.g., specified open enrollment periods, lock-ins)
    - Employee eligibility (e.g. part time / full time, spouse, family);
    - Insurance methodology (e.g. community rating, composite rating, age adjusted rating, banding);
    - Administrative models (e.g. TPA, carrier, HMO);
    - Benefit design (e.g. primary / preventive emphasis, catastrophic emphasis)
    - Formulary issues (e.g., emphasis on generics, preferred drug lists)
    - Payment issues (e.g. copays, deductibles, Medical Savings Accounts)
    - Others
- The design process that follows will be predicated on an approximated value of the resources available, per person, the population, etc., with specific reference to how much community share (subsidization) will be.

Task 2.5: For each of the following, we will generate a brief profile of options where there are choices as to approach. These will be developed prior to their discussion in working group, applying our experience to the data (demographics, the structural characteristics of employment and cultural).

- Employer eligibility (e.g. employer size, non-provision of health insurance). E.g., what does it mean to do 25 and below vs. up to 50?
- Employer enrollment periods (e.g., specified open enrollment periods, lock-ins)
- Employee eligibility (e.g. part time / full time, spouse, family). What are the fundamental structural effects of coverage for part-time employees and the respective contributions by the employer and the community?
- Insurance methodology (e.g. community rating, composite rating, age adjusted rating, banding). What are the options and consequences, relative to employer attractiveness and feasible carrier participation?
- Administrative models (e.g. TPA, carrier, HMO). Are there viable alternatives to a carrier-based structure?
- Benefit design (e.g. primary / preventive emphasis, catastrophic emphasis, Medical Savings Accounts). The purpose and structure of each of these approaches can be differentiated and described, without setting benefit levels.
- Benefits levels (what were referred to as "Payment issues" (e.g. co-payments, deductibles, caps in visits or dollars, out-of-pocket limits). Some discussion here about the relationship of design to behavior, value, and approximation here of what benefits are worth.
- Others (as may be developed)

Task 2.6: Develop a preliminary health benefits plan design. HMA has the ability and the use of our model (developed for Delaware) to price the developed options for the population targeted, with and without an enrollment maximum, projecting an estimated take-up rates were the pilot to go statewide.

Based on the work in Sec. 2.5, we will:

- Identify options for benefits and eligibility criteria.
- Assist in assessment and evaluation of options.
- Develop rate and reimbursement options.

Task 2.7: Assess legal and political barriers

We will attempt to identify all structural and political barriers to implementation of a proposed plan. HMA, working with SIHF staff, will:

- Assist in development of state plan amendments, policy bulletins, and other related items.
- Review policies and procedures for compliance with State and Federal requirements.
- Determine whether a better plan could be offered with an administrative waiver from the Department of Insurance, with subsequent implications for the success of the pilot.

Task 2.8: Develop a preliminary financing plan for project implementation

Financing plan proposals will be developed as a basis for engaging all relevant officials in discussion. We will:

- Meet with State and City officials.
- Review existing financing mechanisms.
- Develop options for special financing.
- Assist in maximizing the level of special UPL funding authorized by the State for hospitals or Federally Qualified Health Centers.
- Work with local hospitals and clinics to maximize the UPL limits so that the options of partners and potential size of the program are as wide as possible.
- Assist in assessment and evaluation of options.
- Otherwise assist in design of financing system.

Phase 3 – Health Plan and Structure Outline (Completion Date: April 25, 2003)

Task 3.1: Completion of health benefits plan design and preliminary cost estimate

- HMA will assist in the compilation of actuarial data, available health benefits options and reimbursement options defined in Task 2.
- HMA staff will work with the state Medicaid agency to extract historical Medicaid and KidCare claims for the St. Clair County area from the state claims file. Provide reports on historical utilization of services for the identified population, including the specific providers who have provided services in the past by the dollar amount of their payments through the Medicaid program.
- Assist in assessment and evaluation of options.

Task 3.2: Develop overall project design including management and administration • HMA staff will assist the local community in design and implementation of systems, including eligibility, reimbursement, member and provider relations, contracting, claims processing, and utilization management. • Assist in framing staffing and identifying functions for the project staff.
Task 3.3: Identify potential financing options, develop sources of funding, grants potential and initial pricing of plan options • Review options for special financing as defined in Task 2.7. • Assist in assessment and evaluation of options.
Task 3.4: Obtain agreement from key constituencies on roles, resources, responsibilities, and incentives for the plan • Through a second set of constituency meetings organized by Southern Illinois Healthcare Foundation, obtain the buy-in of key groups. • Work with the Department of Insurance to assure that plan design, responsibilities and incentives fulfill all regulatory requirements.
Phase 4 – Health Plan and Structure Completion (Completion Date: May 30, 2003)
Task 4.1: Assist in assessment and evaluation of final benefit plan design, management and administration design and actuarial and legal costing for plan design • Assist with determination of final benefit design. • Assist with design of final operations plan including legal structure and administrative design. • Complete assessment of actuarial needs including assessment of various health benefit packages, eligibility criteria, and reimbursement policies, including co-payments.
Task 4.2: Develop RFP and solicit responses from insurers. • Assist in the development of necessary requirements for contracted insurers. • Assist in the development of the RFP to insurers. • Assist in the evaluation and selection of proposal responses. HMA anticipates the active participation of the community in the evaluation of responses. • Work with Department of Insurance to assure that plans acceptable to the community fulfill all regulatory requirements.
Task 4.3: Secure Financing • Assist in finalizing the financing mechanism established in Task 3.3. • Assist in development and execution of necessary contracts between providers, businesses, and State.

Task 4.4: Develop • Assist in identifying tasks and necessary requirements for contracted physicians. • Assist in the development of the RFP for forming a network of physicians, pharmacies and hospitals. • Assist in the evaluation and selection of proposal responses. HMA anticipates that representatives of the community participate in the evaluation of provider responses. • Assure that all network development fulfills the PPA requirements of the Department of Insurance.
Task 4.5: Establish Project launch date and development of the project implementation plan. • Assist in developing timeline for proposals; developing contracts; implementing administration functions, and determining timelines for funding.
Phase 5: Deliverables and Replicability (Completion Date: June 13, 2003)
Task 5.1: Document the development process by developing a Policy User's Guide to facilitate replicability: • Compile preparatory profiles for each of the dimensions brought through committee, and describe the options selected and discarded along each dimension and the reasons.
Task 5.2: Model pricing over three years, for the pilot and statewide.

V. Project Team

HMA proposes a team of highly experienced individuals for this project. Resumes for core project team members may be found at Attachment B, *HMA Resumes.* In addition, the project team may draw on other HMA staff for their expertise in specific areas related to the design of programs for the uninsured.

Steve Scheer, Principal, will serve as the Project Manager for this project. Mr. Scheer brings over 25 years of demonstrated expertise in policy development, health finance, legislative and executive branch advocacy, and the development and marketing of hospital data systems. He has led HMA's efforts to design and implement small employer-based insurance programs in Winnebago and Macoupin Counties (Illinois).

Mr. Scheer has focused his career on developing corporate strategies to aid hospitals with financing issues and serving the uninsured. Utilization of data for policy formulation and strategic planning coupled with creating solutions for providers has been a demonstrated strength. Mr. Scheer assists clients with association strategic planning and member satisfaction improvement, healthcare policy analysis, financial policy options, alternative coverage mechanisms, and the development and implementation of direct contracting initiatives between health providers and purchasers.

Prior to joining HMA, Mr. Scheer served as Executive Vice President of the Illinois Hospital Association where he was responsible for strategies which boosted Illinois to the "top ten" among states in Medicaid cost recovery and doubled Medicaid hospital outpatient rates.

Jonathan Dopkeen, Ph.D., Principal, came to HMA from a career in public policy, management and consulting in health systems delivery, health benefit plans, and human resources. He has been a policy analyst, researcher, public and hospital administrator, and consultant to both the public and private sectors. Public sector clients have included cities, counties and states. Private clients have included manufacturing and financial firms and health systems. His primary focus has been the enhancement of the client's position in the market place through the use of data analytic techniques. Dr. Dopkeen has also played an integral role in developing and modeling plan design options for small employer-based health insurance programs in Winnebago and Macoupin Counties (Illinois).

Dr. Dopkeen has worked in several national actuarial, benefits and human resource consulting firms, most recently as a Government Practice Leader in Chicago. His innovative, data-driven consulting on governmental and corporate programs has impacted operational and financial decisions on health services, retiree medical policy, program management, and other human resource issues including organizational development, compensation, workers compensation and long term care. He has recognized expertise in the data-driven collective bargaining of public employer health plans.

Scott McKibbin, Senior Consultant, has extensive experience with health care data analysis and has recently consulted with several large clients during the collective bargaining process to provide both a common basis for collective bargaining plan change values and insurance carrier negotiations/bidding. Mr. McKibbin assist clients with health care plan designs using claims data analysis/risk profiling; direct contracting initiatives between health providers and purchasers; underwriting and rate setting; benefits strategic planning; retiree medical plan design and rate setting; and plan implementation/communication.

Mr. McKibbin has consulted to the Congressional Research Service (CRS) on the Federal Employees Health Benefits Plans (FEHBP). He has assisted CRS in evaluation of recently enacted federal health care legislation including, the Health Insurance Portability and Accountability Act, Mental Health Parity, Mothers and Newborns Protection Act, and the State Children's Health Insurance Program. He also has assisted the Government Accounting Office (GAO) with an audit of the drug program for the FEHBP Medicare eligible retirees.

Gaylee Morgan, Consultant, brings experience in Medicaid policy and financing, and hospital reimbursement. Recent projects include a review of access to psychiatric services in southeastern Massachusetts, an evaluation of the Medicaid managed care climate in four states and an analysis of Medicaid mental health financing and access issues for a provider in Nebraska. Ms. Morgan is currently part of the HMA team working to

implement a small employer-based health insurance program in Winnebago County (Illinois).

Prior to joining HMA, Ms. Morgan was a financial policy consultant for a major academic medical center where her responsibilities included developing financial models and analyzing the effects of changes in Medicare and Medicaid payment policies on hospital revenue. From 1998 to 2001, Ms. Morgan was a health policy analyst with the U.S. Office of Management and Budget (OMB). At OMB, Ms. Morgan worked with states and the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) on the development of Medicaid 1115 and 1915(b) waivers and analyzed the policy and budget implications of statutory, regulatory and administrative changes in the Medicaid program. Ms. Morgan has a Masters in Public Policy degree from the University of Chicago.

Rekha Ramesh, Consultant, specializes in Medicaid policy and financing issues and the development of programs to cover the uninsured. Recent projects include coauthoring the Medicaid Spending Growth 50 State Survey for the Kaiser Family Foundation and developing both prescription drug discount card programs as well as uninsured programs in Southern Illinois. Ms. Ramesh as also worked on development of a disease and case management program for the State of Indiana's Medicaid program, and a review of State Coverage Initiatives for the Robert Wood Johnson Foundation. Prior to joining HMA, Ms. Ramesh was an analyst with the U.S. Congressional Budget Office where she conducted research on issues related to Medicaid, SCHIP and the uninsured. At the CBO, she coauthored a forthcoming paper titled "Characteristics and Dynamics of the Uninsured."

Ms. Ramesh holds a Masters in Public Policy and a certificate from the Graduate Program of Health Administration and Policy from the University of Chicago. As a graduate student, she completed internships at the Office of Management and Budget in Washington D.C., and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Susan Dombrowski, Consultant, started her career with Health Management Associates in September 2000. Since joining the firm she has assisted clients with health care plan designs using comparative analysis; underwriting and rate setting; cost profiling for Community Mental Health Facilities; determining eligibility for Medicaid matching funds for a large university college of pharmacy; conducting agency reviews on the Homemaker/Personal Care services provided under a Home and Community Based Waiver for the Disabled & Elderly and AIDS population; and conducting assessments on Mentally Retarded and Developmental Disabled individuals on specific Home and Community Based Waivers.

Thomas Donlon, FSA, MAAA, will serve as an actuarial subcontractor on this contract at the discretion of the Department. Mr. Donlon is a consulting actuary with more than 20 years of experience specializing in the health care area. He works with a wide range of clients including insurers, public sector clients, health care providers and employers. Mr.

Donlon has also worked with a variety of different health and welfare plans. These include large group self-insured plans, small group insured plans, dental plans, disability plans and group life insurance plans.

At Donlon & Associates, Inc. (D&A), Mr. Donlon manages projects for a number of significant clients. These projects include developing health and welfare plan rating models, setting trend rates, certifying claim liabilities, preparing actuarial rate certifications, determining FAS 106 liabilities, analyzing claim data, recommending plan design changes, negotiating with plan vendors, pricing defined contribution health plans and evaluating the effectiveness of managed care strategies.

Prior to founding D&A, Mr. Donlon was an Executive Vice President with Aon Consulting, a subsidiary of Aon Corporation in Chicago. At Aon, Mr. Donlon was the National Practice Leader for the Health & Welfare Consulting Practice. Prior to joining Aon, Mr. Donlon was a Principal with William M. Mercer, Inc. (Mercer). There he consulted with both large employers and health care providers. While at Mercer, Mr. Donlon served as a member of the National Managed Care Strategic Planning Committee and Regional Quality Assurance Committee.

Mr. Donlon has been a Fellow of the Society of Actuaries since 1983 and a Member of the American Academy of Actuaries since 1980. He received a Bachelor of Science degree from Loyola University of Chicago with a major in Mathematics.